

The Sequence of Emotional Reactions in Radical Mastectomy Patients

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At the Memorial Hospital in New York, we are in a position to observe the emotional reactions of large numbers of mastectomized women since an average of 580 radical mastectomies are performed each year. Our clinical observations have led to a number of formulations.

In the United States, the female breast is the most common site of cancer. It has been estimated that 4 percent of the adult female population develops the disease. Radical mastectomy is a universally accepted treatment of breast cancer and involves the removal of the breast, pectoralis major and minor muscles, and the axillary contents.

Public knowledge of the symptoms and treatment of breast cancer is more widespread than for other forms of cancer. The symptoms of breast cancer cannot be easily attributed to other illnesses as can the symptoms of rectal or gastric cancer. Most women in our society are aware that a painless mass in the breast is a pathological sign. Furthermore, they have known either relatives or friends who have had a radical mastectomy. Unfortunately, women who have had a mastectomy and are free of recurrent disease rarely allow others to know about it. Those who die from recurrent disease,

despite surgery, are the patients more generally known in the community. As a result, many women regard the prognosis for breast cancer as unfavorable even if treated.

When a woman discovers a mass in her breast, she is likely to recall every unfortunate incident involving breast pathology known to her. As soon as she is aware of the symptom, a sequence of emotional reactions and reality events begins. The sequence can be characterized as consisting of four stages: onset of symptoms, diagnosis, hospitalization for surgery, and convalescence. Each phase contributes to the patient's ability to integrate the total experience, and, modified by her lifelong adaptations in living, sets the tone of her postoperative reactions.

Onset of Symptoms and Diagnosis

When the symptom of breast cancer is recognized, the patient immediately begins to anticipate what she believes is going to happen to her during the treatment process. The individual meaning of the suspected disease and surgical treatment serves to mobilize the patient's anticipatory anxieties and preparatory resources. Often, the symptom arouses such acute anxiety that the patient delays seeking medical attention. Or, if medical help is sought, a series of defensive maneuvers may be initiated to avoid the inevitable treatment process. Fortunately, many women are able to seek medical attention and carry through the necessary treatment.

This does not mean that these women obtain

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medical treatment without great emotional cost to themselves. Because of the amount of information which most women have about breast symptoms, the most frequent concern of the patient is whether or not she has cancer. To most, this concern can be equated with, "Do I have that invariably fatal disease?" However, other important fears may also be activated when the symptom is first discovered. Concern about recurrence if the diagnosis should prove to be cancer is often experienced even before treatment is initiated, or concern about mutilation if surgery should prove necessary is expressed. Some women are particularly worried about the effect of the entire experience on their families—"What will happen to my children when I'm in the hospital or if I die"; others cannot specify their fears—"I'm just scared and I don't know why." With the onset of symptoms, then, the patient immediately begins to anticipate the disease and its treatment.

On the day that the diagnosis is established and the patient is informed of the necessity for surgery, all of her anticipatory fears are brought clearly into focus and invested with reality. Whether or not the patient is told she has cancer will depend on the interaction between the physician's convictions about imparting information to cancer patients, and the patient's insistence to be told details. In either case, however, the patient's dread begins to mount slowly and progressively.

Hospitalization

The day of admission to the hospital has tremendous significance. On this day patients are frequently in a state of panic. The awesome, impersonal routine of preparation for surgery is in itself frightening. Patients interviewed on this day express feelings of being trapped and helpless. Some patients actually telephone their families and request that they be taken home as a last desperate effort to thwart the threatening environment. If they are clinic patients and are placed in a breast ward, they will selectively perceive the operative experience of others. The patient's experiences on the day of admission to the hospital reinforce the fears which arise at the onset of symptoms.

Immediately before surgery, specific fears concerning anesthesia are expressed. A majority of patients insist that total anesthesia must be induced before they can possibly undergo surgery. Some patients ask that they be "completely out" even before going to the operating room. Other patients express fear of losing consciousness as a result of anesthesia. All of the feelings regarding anesthesia are indications of integrative attempts to deal with an overwhelmingly threatening life situation and, again, are very individual.

Other reflections of tension or panic occur prior to operation. Eating patterns are usually disturbed, and restful sleep the night before surgery is an impossibility for most patients, sometimes even with sedation. Dreams occurring on the night before surgery are usually nightmares of intense horror. For example, one patient reported that in her dreams she found herself in a butcher shop with female breasts suspended from meat hooks all around her, although her own breasts were intact. This dream and others of an equally horrible nature emphasize the anticipatory fears of surgery.

Postoperative reactions also attest to the nature of the experience. Once again, horror dreams are frequently reported. Gross physiological reactions, such as excessive perspiration and tachycardia, are manifested. Most patients have difficulty in eating after surgery; they are unable to swallow food, or they have lost their appetites. Again, there are a variety of sleep disturbances: inability to fall asleep, early waking, fitful and restless sleep, and arising fatigued. During the day, some patients sit quietly, sometimes crying, without participating in any ward activity; others are overactive, often eagerly helping nurses with their work.

The gross physiological reactions, disruption of eating and sleep patterns, the dreams, and ward activity all comprise a response to a hostile and injuring environment. These reactions, with marked individual variation, are actually a watchful mobilization of inner resources to prevent further injury. One author has succinctly said that, "the operation' is a milestone—if not a tombstone—in the life of an individual."

Convalescence

"Going home" is viewed with a variety of reactions. Some patients are eager to see their children and families again and feel that only then, with home care, will they be able to recuperate properly. For these patients, family and friends represent the support and warmth they feel cannot be realized in the sterile and symbolically mutilative atmosphere of the hospital. Other patients, however, are not eager to return home either because of feelings of weakness or because they feel unable to "face people." These patients are relating the surgical result to a social context and feel that even the impersonal hospital environment is less threatening than projected fears of social inacceptability.

Following discharge from the hospital, some patients return to their own homes; others to the homes of relatives or friends. Usually, there is a period of rest, which involves staying in bed and a total withdrawal from ordinary activities. The length of time and the extent vary, but withdrawal occurs in almost every case. Some patients insist on others caring for them; others are equally insistent on performing some activity for themselves. Although the actual surgical experience is over, the feelings aroused by it remain active. Many patients complain that their families and friends refuse to discuss the operation "in order that the patient may forget." These patients resent this attitude and feel they would be greatly relieved if everyone would accept the fact and refer to it as they would to other experiences in life. On the other hand, some patients do not wish to discuss the experience at any time. These patients very quickly become hyperactive—doing anything to prevent thinking about the experience.

Regardless of the adaptation a patient achieves in attempting to resolve her feelings about the total experience, support and understanding by her family have an enormously significant role. Some patients report that their families have risen to the occasion by being more overtly understanding and supportive in recognition of the patient's traumatic experience. One woman expressed the feeling that she had never before completely understood how im-

portant her family was to her and how deeply they loved her. This woman was able to resume full functioning very early, ascribing her ability to do so to her family's feeling toward her. The recognition by any woman that she is loved and needed by people who have an important role in her life gives her a sense of value which goes far in restoring the self-esteem lowered by the mutilative surgical experience.

Often, women perceive their bodies as the basis for value in interpersonal relationships. These women relate to their husbands through physical attractiveness. When they feel their bodies have been made ugly by a radical mastectomy, profound feelings of self-rejection may develop. Even if the husband actually remains affectionate and supportive, the patient may feel she has disrupted the relationship and stands in danger of losing him as a result. When this occurs, the lack of self-esteem is projected as the husband's attitude despite his actual expression of feeling. In one instance, a woman reported how kind, warm, and sympathetic her husband had been since surgery, but, nevertheless, she dreamed that he abandoned her.

The occurrence of postoperative physical complications, such as infection or difficulty in healing, constitutes an additional threat. Most women view any complication as evidence of recurrent disease and the need for additional surgery. Acute anxiety and sometimes depression is precipitated by these events. A large number of mastectomy patients are in constant dread of losing the remaining breast. Often, radical mastectomy patients experience painful sensations in the remaining breast, and sometimes actual enlargement of the breast even in the absence of disease or any other physiological finding.

The Experience in Context

The entire experience of the mastectomy patient from the onset of symptoms to the convalescent period has been elaborated. The meaning of loss of a breast to a woman, however, cannot be abstracted out of the context in which the loss occurs. The entire experience involves a series of adaptations which is, in turn, intimately related to the adaptations in

living which the patient has previously made.

It is true that the loss of a breast constitutes a blow to femininity, but femininity has a different meaning to each woman. To the patient who is extramaritally promiscuous, femininity means something quite different than it does to the woman who is as yet chaste and unmarried at a relatively late age. The statement that postclimacteric women will have a more emotionally tranquil course than will younger women who have not fulfilled their goals of marriage and motherhood is an equally meaningless generality since the breast acquires individual meaning to each woman based on her resolution of fears pertaining to the achievement of heterosexuality and motherhood. Some women integrate the breast into a framework of self-esteem in feminine function. Others, on the other hand, integrate the breast as a defense against a feeling of worthlessness as women. These resolutions and defenses are active throughout the life of the woman and do not mysteriously disappear with menopause. The impact of breast amputation upon a woman, therefore, will depend less on her age than upon the character defenses which it disrupts.

It is also assumed that the loss of the breast is in itself the focus of the entire experience. Our observations have indicated that for some women the surgical experience has much greater inherent threat, whereas for others it may be the "emptiness" in the axilla. For example, many women have said, "It wouldn't be so bad if they simply removed my breast, but why did they have to leave this hole." This preoccupation is so pronounced in some that they express the feeling that their bodies feel distorted and crooked.

Understanding Support Needed

We believe that the psychological experience of a radical mastectomy patient consists of a sequence of interrelated events: first, the anticipation of the injury and interference with adaptation; second, the actual injury; third, the reparative efforts to restore the adaptation which the patient had achieved prior to the experience.

The fact that mastectomy surgery for breast cancer is a terrifying experience bears con-

tinual emphasis. It realistically threatens life and has a major impact upon the functioning individual. The mastectomy patient has many problems from the very moment she first recognizes the symptom. If continued psychological invalidism is to be avoided, understanding support must be introduced as soon as the diagnosis is established.

Frequently, women cannot vent their feelings of despair or resentment to the surgeon for fear of rejection and projected retaliation. If the diagnosis is established in a clinic, a routine referral should be made to a psychiatrically trained worker. As much time as necessary should be spent with the patient at this time to encourage her to express her fears and to give her support in dealing with them. Once this contact is made, the patient has the feeling that there is someone in the hospital who is friendly and understanding. This relationship has considerable importance since some patients have stated that it helps to see a familiar face on the day of admission. A continued relationship with a supportive person is necessary in meeting this stressful situation.

Postoperative expressions of dependence or anger are also often given negative interpretation by hospital personnel. Here again, the trained worker can give valuable assistance. Mastectomy patients have been through a trying experience, and dependence is the cry for support in the initial postoperative stages. The goal should not be to break dependency as soon as possible because for most women it is only a temporary phase. Feelings of anger and resentment should be allowed expression since they are usually positive signs. A psychiatrically trained worker will be able to detect when and if dependent or hostile expressions are becoming fixed patterns of adaptation. This, however, occurs very infrequently.

The reparative effort often follows the following pattern after surgery. Most patients are very depressed for some period of time after surgery, whether for an hour or a week or longer. During the depressed period the feeling is usually, "I am doomed, life is over, nobody loves me." The next period is one of self-pity during which the patient is saying in effect, "If nobody cares for me, I'll care for

myself." Self-pity is usually accompanied by feelings of misgiving and guilt and at this time the psychiatrically trained worker can help the patient by assuring her that there is nothing wrong with feeling sorry for oneself. Successful resolution of these feelings results in resumption of functioning and interest in the environment.

We must be entirely realistic in appreciating the terrifying nature of surgical experiences, particularly when an organ of great psychic

significance is involved. Radical mastectomy patients need warm support and understanding if they are to meet the threat of the situation. If this support can be routinely forthcoming to all patients, many women will be spared intense emotional reactions and limitations in living. The radical mastectomy patient can live a full life after cancer surgery but only if we accept our obligation to aid in the process of reducing trauma and restoring function.

Employment of the Physically Handicapped

The Federal-State employment services report the placement of 2,400,000 physically handicapped workers in nonagricultural employment from January 1, 1940, to July 1, 1952. Additional hundreds of thousands of workers with disabilities found employment through other sources.

These cumulative figures, cited by the President's Committee on Employment of the Physically Handicapped in connection with the eighth observance of National Employ the Physically Handicapped Week, which took place October 5 through 11, are indicative of the progress that has been made in placing persons with disabilities into productive employment. The task, however, is a continuing one. It is estimated that another 2 million men and women can be added to the labor force if rehabilitation services are made available to them, according to a report made by a special Task Force on the Handicapped to the Office of Defense Mobilization.

The Veterans Employment Service reports that, in spite of favorable labor market conditions and a record of 124,000 disabled veterans placed in 1951, 40,500 disabled veterans were looking for work in April 1952. An additional 50,000 disabled veterans are taking training or schooling under vocational programs sponsored by the Veterans Administration and will be looking for jobs in the near future.

Additional figures indicative of the success of the efforts in behalf of the physically handicapped and of the work yet to be done come from the Office of Vocational Rehabilitation. During fiscal 1951, the local offices of State divisions of vocational rehabilitation rehabilitated into employment nearly 67,000 men and women. Another 150,000 are receiving services which eventually will enable them to work, about 75,000 of whom will be ready within the next year.

These 67,000 men and women who overcame helplessness in 1951 added more than 100 million man-hours to the Nation's productive effort, according to the Office of Vocational Rehabilitation. They increased their earnings from \$16 million to \$116 million a year.

A breakdown of these 1951 figures indicates that 5,696 of the physically handicapped who found employment had hearing disabilities. About 1,500 were deaf and 4,200 were hard of hearing. These 5,696 people increased their earnings from \$2,300,000 a year to more than \$10,000,000 the first year, an increase of 344 percent.